

**Reducing Child Morbidity and Strengthening Health Care
Systems in Malawi Project:
Quarterly Report Number 4, January to March 2004**

MSH Malawi

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Introduction

The MSH/Malawi programme, implemented with several local and international partners, works within the framework of the Ministry of Health (MoH) Programme of Work, as well as District Implementation Plans (DIPs) from eight districts. Its overall aim is to strengthen public sector responses to prevailing causes of mortality and childhood morbidity, through the MoH's Essential Health Programme. Specific objectives, as stated in Cooperative Agreement 690-A-00-03-0017-00, are to:

- Improve prevention and management of childhood illnesses
- Increase use of malaria prevention practices
- Decentralize the health care system, and
- Strengthen central hospital management systems.

The MSH programme follows on the previous CHAPS project implemented in five districts of Malawi. The number of districts being supported in the current project has increased to eight – Mzimba, Kasungu, Salima, Ntcheu, Balaka, Mangochi, Mulanje and Chikwawa. Additionally, the project strengthens management of two central hospitals, Lilongwe and Queen Elizabeth (Blantyre), continuing but greatly increasing support previously provided by PHR Plus. The programme is being implemented by Management Sciences for Health (MSH) together with three implementing partners – the American Red Cross (together with the Malawi Red Cross Society), Health Partners of Southern Africa (HPSA), and Satelife.

Our operating principle remains that we follow our partners' lead in work planning, technical support, and financing. We work to improve the quality and efficiency of partner activities at all levels, but do not introduce or even promote activities which might be construed as outside the system. We have become increasingly active as our partnership with MoH, districts and hospitals has strengthened.

Throughout this quarter, MSH and its implementing partners continued to strengthen relationships with the central Ministry of Health; with District Health Management Teams (DHMTs) in Balaka, Chikwawa, Kasungu, Mangochi, Mulanje, Mzimba, Ntcheu, and Salima; and with leaders of Queen Elizabeth and Lilongwe Central Hospitals. We became increasingly integrated into implementing and developing the Programme of Work (POW) and District Implementation Plans (DIPs). Significant strides were also made at the community level.

The following report highlights major advances during the past quarter. In each case, the full report provides additional details.

1. Implementation and review of 2003-2004 DIPs

During the past quarter, MSH provided technical and financial support for several discrete activities at the district level, costing approximately \$100,000. Examples of significant activities supported include:

- Support to strengthen health management information systems (HMIS) at facility and district levels
- Improvement of the referral system within the continuum of care
- Problem analysis of supervision with all the DHMTs in the targeted districts
- Editing, finalisation and submission of malaria GFATM (Global Fund) proposals for seven districts to the National Malaria Control Programme
- Enhanced community health work including selection of focal villages in the remaining six districts, formative research in three of the eight targeted districts, training of ITN and DRF Committees, and the integration of behavior change interventions (BCI) into the ITN training
- Supported training of health workers in management and control of diarrhea diseases in Mzimba
- Assessment of VCT service delivery in the district hospitals in the targeted districts
- Outreach VCT service in Chikwawa
- Training of 20 full-time VCT Counselors for Chikwawa and Mulanje

Annex seven provides a complete list of supported activities in our eight districts.

MSH also played a major supportive role in assisting the MoH Planning Directorate to assess implementation of the 2003-2004 DIPs, through development of an assessment tool and its application in all of Malawi's 29 districts.

2. Systems strengthening

There is increasing evidence from many quarters that MSH's effort to strengthen planning and management systems are critical for the sustainability of key health programmes and interventions. While human capacity development and drug supply feature prominently in discussions, we also provide major support in HMIS, infection prevention and quality, supervision, and referral. Effective management systems are also vital for hospital autonomy.

2.1 DHMT support

In a sense, all MSH technical support at the district level focuses on strengthening District Health Management Teams (DHMTs). To initiate support, our central and district-based staff collaborated closely with seven of eight DHMTs to assess current management systems and identify priority actions for further development. Common problems included:

- Absence of policy guidelines for human resource management
- Lack of clear linkages between expenditures and activities
- NORAD funds not used in accordance with guidelines
- Laxity in record keeping
- Irregular and poorly documented DHMT meetings
- Irregular drug supply to health facilities
- Irregular supervisory and clinical visits to health facilities
- Ineffective transport management systems
- Inadequate radio and other communication equipment
- Need for staff training/orientation in planning, computers, data collection and use, as well as other areas
- Weak planning skills, including planning for DIPs,
- Weak NGO participation in DIP planning and implementation, as well as in Extended DHMT meetings
- Critical staff shortages at all levels, causing closure of some health facilities
- Need to initiate Quality Assurance activities.

We are currently working with each DHMT to design a program for strengthening team management systems and skills.

2.2 Supervision

The MSH Child Health Team Leader visited all eight districts during the month of March to assess and discuss supervision issues. DHMT members identified recurrent problems, including:

- Absence of supervision skills at all levels
- Poor planning
- Lack of supervision tools, including checklists
- Inadequate transport and budgetary support
- Inadequate or non-existent reporting, especially for findings and follow-up issues.

DHMT members agreed that programme managers should be oriented to supervision and supervisory tools, an activity which MSH will support during the coming quarter

2.3 HMIS

MSH strengthened its ties with the central Health Management Information Unit (HMIU) and with Assistant Statisticians in all eight districts. We began the quarter with financial support to HMIU's nationwide analysis of gender-related data, based on secondary tabulation of data from clinic records; a report from this data collection is ready and awaiting the PS's approval to be released.

HMIU requested MSH technical and financial support to improve the quality of information being collected in Queen Elizabeth and Lilongwe Central Hospitals. Plans were made (1) to test an HMIU supervisory tool, (2) to determine how supervisory visits should be conducted, and (3) to identify appropriate systems strengthening activities for data collection, aggregation, analysis and feedback.

We also assisted the HMIU to supervise HMIS implementation in Mzimba and Chikwawa, with a view to developing an effective strategy for district HMIS supervision.

2.4 Pharmaceutical logistics

MSH continued to collaborate with DELIVER, but most implementation activities are awaiting the arrival of a staff pharmacist on April 1 and an international consultant expected on April 19. In support of pharmaceutical management and re-ordering, we placed an order for eight computers to be used for implementing Supply Chain Manager within our eight districts.

2.5 Referral

The MSH/MoH baseline survey documented weak referral systems throughout the continuum of care, a problem that will become particularly acute with the further development of VCT. MSH/Chikwawa initiated efforts to improve referral by assisting the DHMT to develop referral forms. Draft forms are to be reviewed by all Programme Coordinators and facility in-charges at the HMIS review meeting in April.

2.6 Quality improvement

MSH continues to work closely with JHPIEGO to support infection prevention in district hospitals. Notable activities included the following:

- MSH sponsored MTAs from Salima and Mulanje to participate in an Infection Prevention training organized by the MoH and JHPEIGO. The two joined 20 DHMT members from Mulanje, Dedza, Dowa and Salima.
- MSH supported the Salima Infection Prevention team to conduct a baseline assessment of all government health facilities in the district. Using the tool for performance and improvement score whereby the required level of compliance is 80 percent, the health facilities scored an average of 8.5 percent while the district hospital scored 13.3 percent.

2.7 Hospital systems

Substantial progress was made this quarter in documenting, and starting work toward improving, hospital management systems. Topics addressed included:

- Integrated performance management systems

- Development of a policy and procedures manual
- Personnel management, including development of a leave management system
- Development of a human resources policy and procedures manual
- Development of a registry system
- Development of a management toolkit for senior managers.

3. Clinical Interventions

While MSH continues to promote the entire Essential Health Programme, we have particularly emphasized malaria prevention and child health, as well the VCT component of HIV/AIDS programs.

3.1 Child health/IMCI

During the quarter, noted child health and primary care specialist Jon Rohde paid a two week visit to Malawi, during which he assessed the programme's nutrition activities and taught a PHC module for the College of Medicine's master's programme in public health. Participants in the College of Medicine course included eight MoH staff from MSH-supported districts; in addition, the College permitted eight MSH district staff to attend without charge. Dr. Rohde and MSH's Child Health Team Leader subsequently visited Nutrition Rehabilitation Units in Dowa, Nambuma, Mangochi and Balaka. In response, several MSH-supported districts plan to develop a nutrition assessment tool and assess NRUs.

3.2 Malaria prevention

MSH is working with staff from the Blantyre Integrated Malaria Initiative (BIMI) and the National Malaria Control Programme to strengthen implementation of Intermittent Presumptive Treatment (IPT), most importantly for increasing coverage with the second dose. We assisted Kasungu district staff to assess IPT in four health facilities, finding lack of IPT equipment and low coverage (particularly for the second dose).

MSH and district partners have identified significant problems in community management of insecticide treated nets (ITNs). In response, we have developed a Chichewa language training manual and supported data collection through formative research to be used for developing behavior change materials to improve implementation of this component. In an MSH-sponsored workshop, HSAs reported weak and even collapsing community-based malaria prevention activities. Major problems include:

- Poorly prepared community structures
- Unavailability of ITNs and redipping chemicals
- Poor understanding of redipping requirements
- Weak or non-existent supervision.

MSH led efforts to revise the Chichewa language ITN training manual in collaboration with partners, and the revised manual awaits field testing. We facilitated addition of a module on behavior change interventions. We also continued to support the redipping of bed nets.

3.3 HIV/AIDS

The MSH team, and especially its Malawi Red Cross component, moved aggressively forward to develop and implement the programme's HIV/AIDS strategy. Specific activities included:

- Induction of an HIV specialist, Enock Kajawo, within the Lilongwe team
- Rapid assessment of existing VCT services within eight district hospitals
- Development and administration of a VCT supply/equipment checklist
- Approval of plans to construct a VCT clinic within the compound of the Ntcheu District Hospital
- Re-establishment of an outreach VCT clinic in Chikwawa
- Support to train 20 full time VCT counselors (five week course) in Chikwawa and Mulanje
- Participation of two MoH staff in a Positive Living Training of Trainers course in South Africa
- Development and administration of a VCT supply/equipment checklist for district hospitals
- Participation of two District AIDS Coordinators (Mulanje and Kasungu) in VCT Management training (organized by UMOYO)
- Finalisation of plans for the Malawi Red Cross Society to hire 16 VCT counselors (two per district).

MSH also played an active role in monitoring and facilitating the availability of HIV test kits (although we did not play a direct role within the supply system).

4. Community Involvement

MSH's Malawi Red Cross Society (MRCS) partners made significant progress during this quarter in implementing the community health/behavior change component.

- **Selection of 20 impact villages** per district was completed in all project districts.
- **Community meetings/briefings** on community project objectives and activities were organized for local leaders in the selected villages.
- **Briefings on C-IMCI** was conducted for IMCI Technical Working Group (TWG) in Salima, Balaka and Mulanje districts.
- **Formative research on selected key child care practices** was conducted in Salima, Mzimba and Chikwawa. Topics addressed included home care of sick children, care-seeking outside the home, referral practices, feeding of sick children, malaria prevention, ITNs, access to treatment including through DRFs,

care of pregnant women, and HIV/AIDS. Tools used included focus group discussions, key informant interviews, and in-depth interviews.

- **Workshops to prepare for Participatory Rapid Assessment (PRA)** took place in Mulanje, Kasungu, and Balaka.

5. Policy Development

5.1 Completion of draft MoH policy on hospital autonomy

During this quarter, the JIP committee received the first draft of the strategic framework which was completed in December 2003. The JIP Committee appointed a JIP Sub Committee to review the draft report. The main Committee is expected to receive a draft policy on Hospital Autonomy early in the next quarter.

5.2 Quality Assurance

The National Quality Assurance policy remains in draft form within the MoH. It has not yet been presented to MoH directors. We are working with appropriate officials to identify and resolve obstacles to full approval.

6. Operations/ Administrative Activities

The Operations/ Administration department continued playing its vital role ensuring proper support was provided to the technical staff both at the district and central level. Efforts were put in place to fill out human resource gaps and logistical requirements notably the following:

- Receipt of 3 additional vehicles
- Replacement of faulty Desktop Computers due to erratic power problems
- Development of a procure plan for District Laptops and Desktops for the district pharmacies
- Confirmation of refrigerator and communication (Radios) requirements in the targeted districts as revealed by the MoH/MSH baseline survey.
- Invitation of bids for the construction of the following:
 - MSH Office in Balaka
 - Hospital Autonomy Office and Computer Lab at the Lilongwe Central Hospital.
 - Ntcheu VCT Centre
 - Chikwawa MSH Office
 - Secure Car Port for Mulanje District
- Recruitment of the Activities Coordinator

Annex six highlights details of the above activities.

Annex I

Support for District Implementation Plans

1. Implementation and review of 2003-04 DIPs

MSH provided technical assistance to develop a tool used to assess current DIP implementation. This tool was used in all districts in Malawi by five teams deployed to do the assessment; each team contained at least one MSH staff member. The assessment determined a couple of key issues with regards to DIP implementation:

- Once developed, DIPs were not used as planning or monitoring tools for implementation of activities
- Significant stakeholders were little involved in the development of DIPs
- There was little co-ordination of DIP activities by the DHMT.

Following the review an approach was taken to respond to these issues.

- Support DHMT members with DIP development through a series of workshops.
- MSH staff helped in the design of the second round of workshops, developed a presentation for training purposes used at these workshops and helped co-facilitate a number of sessions.
- The review brought to light serious problems with financial management and the MoH ran a course on financial management for district accountants from all 27 districts.

2. Development of 2004-05 DIPs

To enhance monitoring of the DIP implementation process, the Central Ministry Planning Unit organized a DIP software training at the central level where MSH was invited to participate. Through discussions between the two parties, all eight MSH districts were invited to participate. MSH central level staff and eight MSH MTAs supported the training of DHMT members from all twenty nine districts in use of the DIP software at centrally located places in Mzuzu, Lilongwe and Blantyre. It is also worth mentioning that technical inputs were provided to the MoH on how the DIP software could be improved and used for more effective DIP monitoring.

MSH provided direct support for DIP development by helping five districts (Balaka, Ntcheu, Salima, Chikwawa and Mulanje) to conduct sub-analyses of data from the MSH/MoH baseline assessment. In each case, we assisted two DHMT staff to analyze district-specific results, helping to empower them to use data independently. Results have been disseminated to the DHMTs and district stakeholders. A lot of managerial implications have resulted from the baseline assessment as some revelations were a shock to DHMT members particularly on such issues like supervision, equipment and drug availability etc.

MTAs worked towards preparing an environment for appropriate DIP development for 2004-2005. In some cases, extended DHMT meetings were arranged where respective

DHMTs and partners were able to review current DIP implementation and use these as a basis to plan for the next year. DIP development meetings were funded with participation of non-MoH stakeholders and technical support was provided in developing the DIPs. To date all eight MSH districts have developed first draft DIPs.

Annex II

Systems Development

1. DHMT support

In a sense, all MSH technical support at the district level focuses on strengthening District Health Management Teams (DHMTs). To initiate support, our central and district-based staff collaborated closely with seven of eight DHMTs to assess current management systems and identify priority actions for further development. Common problems included:

- Absence of policy guidelines for human resource management
- Lack of clear linkages between expenditure and activities
- NORAD funds not used in accordance with guidelines
- Laxity in record keeping
- Irregular and poorly documented DHMT meetings
- Irregular drug supply to health facilities
- Irregular supervisory and clinical visits to health facilities
- Ineffective transport management system
- Inadequate radio and other communication equipment
- Need for staff training/orientation in planning, computers, data collection and use, as well as other areas
- Weak planning skills, including for DIPs
- Weak NGO participation in DIP planning and implementation, as well as in Extended DHMT meetings
- Critical staff shortages at all levels, causing closure of some health facilities
- Need to initiate Quality Assurance activities.

MSH will review and discuss these on case by case basis as they vary from district to district and jointly with the DHMT agree on the way forward to ensure that they do not hinder progress of interventions being put in place.

A matrix is attached as Annex XX guiding where each district pertaining to specific areas.

2. Supervision

The MSH/MoH baseline survey conducted in September/October identified inadequate supervision as a major problem contributing to ineffective service delivery, poor quality, and unsustainable health services. During March, the Child Health Team Leader worked with DHMTs, MTAs and district coordinators in all eight districts to discuss and assess supervision issues. The purpose of the meetings was to begin to engage DHMTs and coordinators in supervision discussions, to get the DHMT to share their experience with

supervision in their district, to discuss supervision findings from the baseline survey, and to decide on how to move forward.

During the discussions the DHMT members identified recurrent problems which included:

- Lack of managerial supervision skills
- Lack of supervision tools and checklists
- Inadequate transport and budgetary support
- Inadequate or non-existent reporting, especially for findings and follow-up issues at health facility level.

DHMT members agreed that programme managers should be oriented to supervision and supervisory tools, an activity which MSH will support during the coming quarter.

Responding to the above, MSH requested a meeting with the central ministry to learn about MOH organisation for supervision. MSH always wanted to share information from the district experiences as well as a supervision manual and approaches used in other countries. The meeting provided an opportunity to learn about the MOH supervision structure and the evolution this has gone through over time, from having regional offices responsible for supervision, to Central office responsibility, and now moving into zonal structures.

After consulting the ministry, MSH assessed its options for supporting supervision systems. A consensus was reached that orientation of programme managers be done and that focus be initially on only four districts: Chikwawa, Mulanje, Kasungu and Salima. If the system works well in these districts, then a rollout would be done to the remaining districts. However it was agreed that consultation with MOH would be needed before selecting an appropriate model.

3. Integration into the DHMT and district health system

Programme staff continued to participate in DHMT meetings during the current quarter, giving both parties an opportunity to learn from each other. Participation also facilitated responses to some interventions requiring urgent and higher level decision making.

Coupled to the above was the introduction of MSH staff and activities to the District Assemblies and other stakeholders in the districts. This was considered very important as Malawi devolves government functions.

In Kasungu, MSH supported a two-day extended DHMT meeting which brought together other partners in the district who are engaged in health activities. One major area of discussion was a review of the DIP. The review helped DHMT members and stakeholders review their performance despite the limited information which was available. This was an eye opener to the most members of the DHMT, the Coordinators and other stakeholders who were present at the meeting.

A one day extended DHMT Meeting was organized and funded by the Mzimba District Health Officer. The main agenda was to receive partner activity plans for the 2004/05 implementation year. This was in preparation for DIP formulation exercise described above. Ten NGOs, four CHAM hospitals, and twelve DHO coordinators presented their plans. MSH provided technical support.

MSH Chikwawa has facilitated monthly Coordinators' meetings to share activity information and any new developments and problems encountered. Where there are problems, the Coordinators brainstorm to find long term solutions and refer to the appropriate authorities when necessary. Joint calendars are developed to ensure smooth implementation of planned activities. This activity has enhanced team spirit and openness amongst staff. It is envisaged that these meetings will promote transparency and accountability among staff.

4. HMIS

MSH strengthened its ties with the central Health Management Information Unit (HMIU) and with Assistant Statisticians in all eight districts. All districts submitted plans to be supported; however, the MoH advised to delay implementation of many activities to accommodate OJT on the new HMIS registers, as distribution was in progress during the period.

5. Gender HMIS data collection

We began the quarter with financial support to HMIU's nationwide analysis of gender-related data, based on secondary tabulation of data from clinic records; a report from this data collection is ready and awaiting the PS's approval.

6. HMIS Supervisory Visits

The Assistant Statistician in Chikwawa supervised and provided OJT to 13 health facilities regarding HMIS. Some of the major activities conducted were:

- Review indicators and discuss performance
- Assess timeliness and completeness of reporting
- Share facility performance with staff and Health Centre Advisory Committee
- Make recommendations pertaining to the performance of the health facility (whether it is improving or not in each specific area.).

While the DHMT appreciated support for HMIS supervision, they noted that the Assistant Statistician needs to include someone with a clinical background to support interpretation of certain data elements so that effective interpretations and conclusions are made.

In response to the Mzimba DHO's request to support HMIS supportive supervision, a three day visit to five health facilities was conducted by staff from central Ministry, MSH central office and district staff and the Assistant Statistician. It was interesting to note that while the district level picture was not admirable, one health centre, Emsizini Health Centre had successful and timely use of locally generated information. Such lessons can be shared through a regular network of Zonal and facility staff, which has been included in the next quarters' plan.

It is envisaged that intensified efforts in HMIS supervision and review will increase the quality and quantity of health information collection. Presently, not all facilities return information and often, returns are insufficient and not sent on time. It should also increase the use of information for improving service delivery. Hardly any health facility visited during the MSH/MoH baseline survey used information collected at facility level and district level information filtered back to only 4.3 percent of health facilities.

7. Support to HMIU to Supervise Central Hospitals

The Central HMIS Unit requested technical and financial support visits in Queen Elizabeth and Lilongwe Central Hospitals to improve the quality of information being collected. In response, MSH decided to call a meeting with the central HMIU to determine the most effective way to conduct the supervision and as well map out strategies for sustaining supervision. The meeting yielded a scope of work for:

- Testing a supervisory tool that had been developed by the MoH staff, and which assessed the processes around information flow from data collection, aggregation, analysis and feedback
- Determining aspects that require interventions to strengthen data quality
- Determining how supervisory visits should be conducted, and how these could be developed into a sustainable process.

The meeting participants agreed that an external consultant will support supervision in the first week of April. The consultant will, among other things, explore HMIS logistics, review the data collection process and evaluate local problems.

8. Improving Referral System

The MSH/MoH baseline survey documented weak referral systems throughout the continuum of care, a problem that will become particularly acute with the further development of VCT. This is compounding the problem of lack of continuity of care to patients when they return to their first level and nearest point to access health care. MSH helped Chikwawa and Balaka districts initiate referral activities.

MSH Chikwawa provided technical support to the DHMT to develop referral forms that should be used by health workers at all levels in the system. The draft forms are to be

reviewed by all Programme Coordinators and health facility in-charges in April before they will be endorsed by the DHMT. In addition, a policy guiding the same will be developed. It is hoped that the system will improve patient care, particularly for home based care.

The problem of referral and back referral notes between health facility and district level in Balaka was found to be due to lack of forms and lack of clarity in some areas. MSH provided financial support to Balaka to review and print more forms. A total of 500 forms were printed and 50 per health facility were distributed. Currently usage is being monitored to be reported in the following quarter.

9. Pharmaceutical Logistics

MSH continued to collaborate with DELIVER, but with most implementation activities awaiting the arrival of a staff pharmacist on April 1 and an international consultant expected on April 19. In support of pharmaceutical management and re-ordering, we placed an order for eight computers to be used for implementing Supply Chain Manager within our eight districts.

10. Quality Improvement

The Child Health Team Leader worked with DHMTs, MTAs and district coordinators in all eight districts to discuss a proposal for working on a quality improvement activity with two selected facilities. All DHMTs were enthusiastic and agreed to participate. The expected outcome is to make these facilities models in the districts so that the others can emulate the practices in these health facilities.

11. Infection Prevention

MSH continues to work closely with JHPIEGO to support infection prevention in district hospitals. Notable activities included the following:

- MSH sponsored MTAs from Salima and Mulanje to participate in a Infection Prevention training organized by the MoH and JHPEIGO. The two joined 20 DHMT members from Mulanje, Dedza, Dowa and Salima.
- MSH supported the Salima Infection Prevention team to conduct a baseline assessment of all government health facilities in the district. Using the tool for performance and improvement score whereby the required level of compliance is 80 percent, the health facilities scored an average of 8.5 percent while the district hospital scored 13.3 percent.

Several activities have been planned for in the following quarter to address the situation which are currently too far from the required level of compliance.

Annex III

Clinical Interventions

Several activities took place in the quarter. This annex provides an insight of these activities under the following headings:

- Child Health/IMCI
- Malaria Prevention
- HIV/AIDS

1. Child Health/IMCI

1.1. Support to College of Medicine Masters in Public health

During the quarter, noted child health and primary care specialist Jon Rohde paid a two week visit to Malawi, during which he assessed the programme's nutrition activities and taught a PHC module for the College of Medicine's master's programme in public health. Participants in the College of Medicine course included eight MoH staff from MSH-supported districts; in addition, the College permitted eight MSH district staff to attend without charge. Dr. Rohde and MSH's Child Health Team Leader subsequently visited Nutrition Rehabilitation Units in Dowa, Nambuma, Mangochi and Balaka. In response, several MSH-supported districts plan to develop a nutrition assessment tool and assess NRUs.

This was also an opportunity to the College of medicine to build its institutional capacity in the public health area by benefiting from the visit of Dr. John Rhode.

1.2. Training on Diarrhea Management– Mzimba

A two day workshop on Management of Oral Rehydration Therapy (ORT) was held from 1 – 5 March 2004. The two session workshop was organized in response to findings of an assessment during supervision which had found a majority of health centres without functional ORT corners. Twenty-eight men and twenty four women from 52 health facilities attended the largely participatory and problem solving training. The following issues and solutions were workshop products:

- Health facilities lack or have inadequate equipment and supplies for ORT corners. This situation limits and in some cases disallows immediate administration of oral rehydration salts to children with diarrhea. The result is unnecessary costs to the government and to the caretakers who must travel long distances to bigger hospitals for simple oral rehydration therapy.
- Ineffective information dissemination for behaviour change. Information on management of diarrhea at home is not effectively reaching all child care takers as also confirmed by the MSH/MoH baseline survey which found only 43 percent of

care takers indicating that they would give ORS or Thanzi or other fluids to a child with diarrhea. MSH will support development of targeted information on family practices through the community IMCI strategy. The aim will be to empower families with information on diarrhea management at home so that children do not reach dehydration state.

- Overworked hospital/ward attendants who do not have enough time for one-to-one education and demonstration of ORT management at home. MSH has already initiated discussions with DHMTs on programme performance review. Among other purposes, the review sessions will assess and suggest efficient time usage by staff at all levels.

1.3 IMCI TOT trained in Balaka

Balaka was one of the districts that had no trainers and almost no staff trained in IMCI. MSH supported a training of 18 trainers in early March. The qualified trainers are expected to facilitate and support IMCI activities within the district. Follow-up and supervision is planned for the next quarter.

1.4 Support Supervision to IMCI trainees

Participants in IMCI training sessions conducted in 2003 were followed up in four health facilities to find out how they were implementing IMCI activities at their duty stations. MSH provided the financial support to this activity. It is encouraging that care practices have improved amongst health workers, indicating that new skills are being put into good use. The rest of the trainees in the other health facilities will be followed up in the following quarter.

2. Malaria Prevention

2.1 Editing of Global Fund Malaria Proposals

As reported for the last quarter, MSH assisted seven districts to develop and submit proposals to the malaria Global Fund. As per the direction of the review panel, the Malaria Specialist spent time editing the proposals with all the district teams except Ntcheu for final submission to the NMCP. The encouraging news is that the review panel had, in principle, approved the proposals.

2.2 Strengthening Intermittent Presumptive Treatment (IPT)

MSH is working with staff from the Blantyre Integrated Malaria Initiative (BIMI) and the National Malaria Control Programme to strengthen implementation of Intermittent Presumptive Treatment (IPT). We assisted Kasungu district staff to assess IPT in four health facilities, finding lack of IPT equipment and low coverage (particularly for the second dose). A comprehensive assessment that will also look at IPT coverage is planned for the next quarter.

2.3 Training of Mzimba HSAs in ITN Management

MSH supported ITN refresher training for 15 HSAs in Mzimba. Participants discussed significant issues in ITN management:

- *Poorly prepared community structures.* ITN promotion had initially been entrusted to volunteers who had been briefed away from village leaders. This omission left out checks and balances which are normally the responsibility of Village Health Committees. MSH has since then supported training of whole VHCs as explained below. It is anticipated that lessons learnt from the organisational and management skills of the 15 HSAs will be replicated in other parts of the district. The HSAs received additional TOT skills so that they could take charge of training VHCs and local leaders.
- *Unavailability of ITNs and Redipping insecticide.* HSAs discussed untimely replenishment of ITNs. Many communities last had their last ITN replenishment in 2000. This was also confirmed by the baseline survey where several pregnant women cited unavailability of ITNs at the health centre and in the community as an added reason for not owning a bednet. Many more had not redipped their bednets because of lack of insecticide at the health centre or in the community. However, with support from MSH, mobilisation through drama, music and leaflets, thousands of ITNs were redipped during the Child Health Days in 15 communities in December 2003.
- *Weak Supervision.* HSAs discussed how infrequent supervision at district health centre and community level had negatively affected expansion of ITN and other malaria prevention activities. Lack of transport for district and health centre implementers was felt to be a top-most supervisory constraint. According to the baseline survey, fewer than 10 percent of health facilities reported having been visited by the malaria coordinator. MSH will in the next quarter provide 100 bicycles to increase HSA mobility. A motorbike will be provided to facilitate visits to health centres, by DHO based supervisors orienting.

2.4 Chichewa ITN Management Training Manual

MSH and district partners have developed a Chichewa language training manual and supported data collection through formative research to be used for developing behavior change materials to improve implementation of this component.

Considering that increased and proper use of ITNs requires behavioural change, it was envisaged that some aspects of behaviour change be integrated into the ITN training. To this effect, MSH central provided technical and financial support to Balaka DHMT.

2.5 Bednet Delivery for Community Distribution

MSH facilitated the delivery of 100,000 mosquito nets for Mzimba and Salima districts. These nets were donated to the National Malaria Control Program for distribution to all

districts. Owing to problems of transport, the program was unable to distribute the nets without delays.

2.6 Training for Mzimba Community Volunteers

The main purpose of the orientation was to empower VHCs and village headmen to manage ITN revolving funds. HSAs who were trained in ITN management were the key facilitators with some limited support from district supervisors. 150 VHC members and 15 Village headmen participated in the two day orientation. Key areas discussed included:

- Nature of malaria disease (causes, signs and symptoms, treatment and prevention)
- ITNs (uses, retreatment and practical lessons on use and redipping)
- Community organisation/structures (IEC and mobilisation, ITN promotion, revolving fund concept, roles and responsibilities of VHCs and volunteers in ITN management, record keeping management of funds and management of supplies).

MSH has provided the necessary record books and equipment for redipping.

2.7 Sensitization of Area Development Committees in Mangochi

The Mangochi DHMT conducted a sensitization meeting of Area Development Committees for the Mangochi, Namwera and Monkey Bay Zones on community zones on ITN management including distribution management. 120 Committee members of the ADCs in the three zones were trained. It is envisaged that this group of people will sensitize a wider group of community members and likely create demand for ITNs.

3. HIV/AIDS

The MSH team, and especially its Malawi Red Cross component, moved aggressively forward to develop and implement the programme's HIV/AIDS strategy. Specific activities included:

- Induction of an HIV specialist, Enock Kajawo, within the Lilongwe team
- Rapid assessment of existing VCT services within eight district hospitals; development and administration of a VCT supply/equipment checklist
- Approval of plans to construct a VCT clinic within the compound of the Ntcheu District Hospital
- Introduction of an outreach VCT clinic in Chikwawa
- Support to train 20 full time VCT counselors (five week course) in Chikwawa and Mulanje
- Participation of two MoH staff in a Positive Living Training of Trainers course in South Africa
- Development and administration of a VCT supply/equipment checklist for district hospitals

- Participation of two District AIDS Coordinators (Mulanje and Kasungu) in VCT Management Training (organized by UMOYO)
- Finalisation of plans for the Malawi Red Cross Society to hire six VCT counselors (two per district).

3.1 Orientation on HIV/AIDS Activities

The HIV/AIDS Specialist visited the eight targeted districts to acquaint himself with the existing situation. Visits revealed that various NGOs, CBOs and government departments are implementing activities focused on HIV prevention, care and support. A quick synopsis came out with the following notable list of the activities:

- Home based care
- Adopt a village
- Food distribution to chronically ill and orphans
- Voluntary counseling and testing
- Prevention of mother to child transmission
- Youth friendly health services
- Information Education and Communication
- Behavior change interventions
- Orphan care
- Cross border HIV/AIDS prevention (Mulanje)
- Management of Sexually Transmitted Infections
- Management of AIDS Related illnesses
- Life skills for young people
- Condom distribution

Though perhaps incomplete, this inventory will help MSH and MoH counterparts focus on areas of collaboration and cooperation to ensure effective and sustainable interventions are put in place.

3.2 Assessment of VCT Service Delivery

Orientation visits also provided an opportunity to assess VCT sites. All district hospitals are providing VCT services but quality differs from one district to another.

- Kasungu , Mangochi, Chikwawa, Mulanje and Balaka each have a room dedicated for VCT services., but Mzimba, Salima and Ntcheu do not.
- District hospitals have an average of five counselors each, but most have other responsibilities; counseling is an added responsibility. Kasungu and Chikwawa each have one full time volunteer counselor, and in Mulanje there are two HSAs who have been trained as full time VCT counselors.

- All district hospitals are performing Whole Blood Rapid HIV testing which is done at the laboratory by the lab technician. Because testing is not done in the counseling room, there are delays in obtaining results from the laboratory.
- All district hospitals had not reported stock out of HIV kits six months prior to the visit.
- All district hospitals reported doing internal quality control of HIV test kits.
- The number of people accessing VCT services is increasing as time goes by. Each hospital reported an average of ten clients/day.
- All hospitals are keeping records, but there is no proper coordination with the HIMS person. Although files to keep records are available, some of the records are loose and may easily get lost. All hospitals are using HIV serology forms to collect information from clients whether sick or those who just walk in.
- Each district has requirements for VCT service delivery, especially: Furniture for VCT rooms, Renovation /expansion/construction of VCT rooms, HIV test kits and supplies, Stationery, Posters and leaflets on VCT guidelines, National HIV Policy, PMTCT guidelines and infection prevention.
- High demand for training. Counselors requested to be trained in performing Whole Blood HIV Rapid Tests.

A strength and weaknesses analysis was then conducted after the assessment to help define the strategies of intervention in the HIV/AIDS activities as defined below.

Strengths of VCT Services

- Commitment by all DHOs to have counseling services at district hospitals.
- VCT services are available to the public from Mondays to Fridays
- Clients are able to go through Pre and Post Test counseling on the same day.
- There is no interruption of services because there is always a counselor. The situation is better in facilities where there are full time counselors.
- There was no stock out of HIV test kits for the past six months.

Weaknesses of VCT services

- Some counselors underwent only a one week counseling training, hence their capacity in handling counseling issues is weak.
- Lack of performing HIV testing in the counseling room.
- There are delays in getting laboratory results, so some clients stay long hours before they go through the post test counseling process.
- Lack of full time counselors compromises counseling services especially over the weekend where some clients would like to access these services.
- VCT rooms in Balaka, Mangochi and Chikwawa are located in places that do not provide privacy to clients.
- All VCT sites lack a waiting area and the entrance into the counseling room is also used for exiting after post test counseling.

From the above analysis, the following recommendations were made:

- There is a need to negotiate with DHOs in Salima, Balaka, Mangochi and Chikwawa to identify rooms which will be renovated into VCT rooms.
- VCT Counselors should be trained in performing whole blood HIV testing so that they should perform tests in the VCT room.
- VCT counselors should be trained in data collection and analysis.
- The recruitment process of full time VCT counselors by Malawi Red Cross should be complete by early May to prepare for their training.
- District AIDS Coordinators/VCT Coordinators and MTAs should be oriented in VCT management.
- Each district should develop or include activities on VCT implementation plan in the DIP.

3.3 Scaling Up of VCT in Chikwawa

Chikwawa district initiated the introduction of an outreach VCT clinic with the aim of promoting access and scaling up VCT services in the district. The activity started as planned but came to suspension because the district ran out of test kits. However, at the time when they were suspended, three sites: Maperera Health Centre, Mchalo Trading Centre and Ndakwela Health Centre had already benefited from the service. A total of 184 clients had been tested and counseled, out of whom 41 females and 8 males were reactive representing 19.5 percent and 9 percent positive rate for women and men respectively. The exercise will resume once the kits are available.

3.4 Training of VCT Counselors in Chikwawa and Mulanje

Responding to the needs of the DHMTs that Chikwawa and Mulanje lack trained counselors and that most of those in place take counseling as a part time job as they double with other duties, MSH supported training 20 full time VCT counselors for a full five weeks. Participants included 15 Health Surveillance Assistants (ten from Mulanje and five from Chikwawa) and five Community Volunteers from Chikwawa. These cadres will ease pressure on overworked staff in the health facilities and as well scale up VCT services, particularly in Chikwawa where they will even conduct outreach VCT services. The Counsellors are expected to take up their posts in April.

3.5 Participation in Positive Living ToT

MSH supported the participation of the ARC HIV/AIDS Coordinator and two MoH staff in the positive living ToT held in Nelspruit, South Africa. MSH is participating in the technical working group to develop a Malawi-specific positive living training manual for service providers, such as VCT Counselors, who directly interface with PLHA. The principles of positive living include:

- Employing methods to extend the average period of asymptomatic HIV infection and treating HIV as a chronic manageable condition.
- Beginning with basic hygiene and access to clean water and eliminating chronic intestinal infections that provoke a chronic immune system response, reduce the body's ability to absorb nutrients, damaging the body's intestinal tract, and diverting resources away from fighting HIV infection.
- Consuming a diet that includes more energy, protein, and foods rich in certain micronutrients believed to have a significant impact on slowing HIV progression (selenium, Vitamin A, zinc, Vitamins B12, C and E).
- Promoting home gardening, using waste water and composting, for a steady, year-round food supply.
- Using locally available foods and herbs for home remedies to manage opportunistic infections and balancing the immune system.
- Using psycho-neural immunology (PNI) to reduce stress and strengthen the immune system.

3.6 VCT Management Training

The HIV Specialist and District AIDS Coordinators from Mulanje and Kasungu attended a VCT Management Training, organized by Umoyo Network. The training drew NGO partners supported by Umoyo Network from Ekwendeni mission hospital, Nkhoma mission hospital, Tovwirane, Nkhotakota AIDS Support organisation, Salima AIDS Support Organisation, Adventist Health Services, Malamulo Hospital and MACRO. The workshop aimed to develop VCT management capacity among Umoyo NGO partners and MSH. Objectively, the workshop focused on:

- Orienting participants on the main components of the National VCT Guidelines.
- Orienting participants to the concept of VCT as an HIV prevention and care strategy.
- Equipping participants to the concept of VCT with knowledge of various VCT models, HIV counseling protocols, protocols and algorithms for HIV testing, ethical and legal issues relating to VCT.
- Equipping participants with knowledge and skills of the processes of planning implementing and managing VCT services.
- Equipping participants with knowledge in VCT services monitoring, evaluation, and management of data and information systems.

The MSH team that attended the training made the following recommendations:

- Conduct a three day orientation on VCT Management for District AIDS Coordinators/District VCT Supervisors and MTAs in the following quarter.
- Develop a VCT implementation plan for each district which will facilitate setting up of quality VCT services.
- DHOs should allocate VCT rooms with adequate space which require renovations.
- Renovation of VCT rooms should start as soon as VCT rooms are identified.
- Procurement process of furniture for VCT rooms should start as soon as possible.

- Recruitment process of full time VCT counselors should start as soon as possible.
- HIV Policy and VCT guidelines should be made available to all VCT sites.

3.7 Other Notable Achievements/Issues

- An additional component was added to the Scope of Work of MRCS and ARC for the program whereby MRCS will facilitate the secondment of Voluntary Counseling and Testing Counselors to the MoHP district hospitals where the program is operating. The concept paper and budget have been finalized. Recruitment and training of Counselors will take in second quarter.
- The program has established an HIV/AIDS workplace policy task force comprised of various cadres of staff members. The task force will take the lead in drafting the organisation's staff workplace policy on HIV/AIDS.
- Collaborating with Umoyo Network on improving availability of rapid test kits, strengthening management of VCT services, capacity building of VCT managers and the positive living training manual development.
- Substantial progress made on adaptation of a training manual for reducing HIV-related stigma among health service providers. This approach has been used in other African countries to help health workers understand HIV in the context of infection prevention and patient and health worker rights. Health facility staff will undergo a series of exercises in an orientation lasting approximately three days per group. Topics to be covered include values clarification about HIV/AIDS, stigma and discrimination towards PLWA, standard precautions for infection prevention, detailed guidance for preventing occupational injury and exposure to HIV, post exposure care, HIV testing issues in the health care setting, and how to develop action plans which address the issues above. The pilots, scheduled in two districts next quarter, will be assessed for effectiveness and appropriateness using participatory monitoring and evaluation and rolled out accordingly if successful.

Annex IV

Community Involvement

1 Orientation for Balaka IMCI Technical Working Group (TWG)

The orientation follows a briefing done last year for the district IMCI coordination committee and focused on the multi-sectoral approach to Community IMCI. The TWG is a subcommittee of the main coordination committee and was briefed on the 17 recommended care practices and procedures for implementing C-IMCI, especially behavior change interventions (BCI). BCI complements Community Dialogue and uses multi channel communication, advocacy role for soliciting political support, improving Community Based Service Providers skills, provision of required materials/drugs to meet community demands, and strengthening of linkages and collaboration between health facility and communities. It is hoped that orientation will enhance the relationship between stakeholders and the MSH/MoH programme and as well provide access to other channels of channeling information and resources for the benefit of the communities that the programme is striving to reach.

2. Tool development for Participatory Rural Appraisal (PRA)

Enhancing efforts to implement the community component, MSH facilitated a planning workshop for C-IMCI activities in Mulanje district. The 27 participants included DHMT members, MSH staff, government departments, NGOs and - from the selected 20 impact villages - facility staff, HSAs, volunteer representatives, Traditional Authority and Group Village headmen. The workshop developed three tools to be used for the PRA in the selected villages, including a questionnaire guide for Focus Group Discussions (FGDs), a questionnaire for structured interviews, and a transect walk guide. A village activity plan format was also agreed upon for C-IMCI a village activities. It is envisaged that the tools will aid data collection for the formative research and will be adapted in the other districts.

3. Formative Research

Community level behavior change is essential for success of the MoH's child health and malaria prevention interventions. To ensure that the strategy is built on current and evidence based information, MSH is collaborating with DHMTs in Chikwawa, Salima and Mzimba to conduct formative research. Data sources include separate focus group discussions with women, men, male youths, female youths and village headmen. Topics covered touched on home care of sick child, seeking care outside home/referral, feeding of sick children, malaria prevention, access to treatment, care of pregnant women, and HIV/AIDS. Analysis of information is still going on and will be presented to the communities for action prioritisation as soon as the results are ready.

4. Assessment of Drug Revolving Funds

The MSH/MoH baseline assessment survey assessed the availability of DRFs and those that were active. However, the assessment criteria fell short of the definition of actual active DRF. The Chikwawa DHMT with support from MSH developed criteria and assessed 10 DRF committees in March. During the assessment the assessors looked at the following:

- Membership composition of the DRFs and reorganize/refill in position if there is need.
- Assess functional status of the DRF (active/passiveness/dead)
- Identify possible sites for DRF/ITN trainings
- Drug stocks availability
- General problems and challenges met during DRF implementation and possibly suggest solutions.

The aim is to mobilize these DRFs so that they become active and scale up community level activities including selling ITNs. The report of the findings is to be included in the next quarter

Annex V

Hospital Autonomy

This annex outlines activities that have been undertaken by the Hospital Autonomy Program for period January to March 2004 based on the MOH Work plan for Hospital Autonomy for the period July 2003 to June 2004. Activities were undertaken at all three levels, namely:

- national level in support of the Ministry of Health
- central hospital level in strengthening management systems and
- district level in supporting improved functioning of the health system

1 Strategic framework and implementation plan

The Draft National Strategic Framework was completed and presented to the JIP Subcommittee on 6 February 2004. The Strategic Framework was well received and a Task Team comprising of 7 senior members was commissioned to review the draft and convert it into a Draft National Policy on Hospital Autonomy.

The task team met for a weekend in Zomba and made the following changes to the document:

- Textual corrections and slightly changed format.
- New section on functions of an autonomous hospital from the Draft Act Section 3.4
- A considerable expansion on Hospital Performance Contracts as this will be the main tool for managing the new relationship.
- Combined the sections on levels of care and types of hospitals with less background and more focus on terminology.
- Shortened section on national planning.
- Removal of most references to mission hospitals and a very small section on other hospitals to highlight that hospital autonomy can be implemented beyond central hospitals.
- Revised section on implementing hospital autonomy that outlines the Roadmap and highlights key interventions (i.e. what will be done as opposed to the process)

The Draft National Policy on Hospital Autonomy will be submitted to the Main JIP Committee in May for consideration by senior officials from the MOH and donor partners.

The team leader attended the Departmental Review of the Annual Work plan for the Clinical Services Department for July 2003 to June 2004. A progress report was submitted and the Work plan for Hospital Autonomy was revised in the light of progress to date. The director expressed satisfaction with the progress made on Hospital Autonomy in the last 6 months.

2 Bill on hospital autonomy

The Zero Draft of the Hospital Autonomy Bill (that was completed in July 2003 after the Legal Workshop in May 2003) will be reviewed in the light of the new policy on hospital Autonomy once it is approved by the MOH. It is hoped that the Hospital Autonomy Bill will be tabled in Parliament during the second session after the elections at the end of 2004.

3 Central hospital management systems

3.1 Integrated performance management system

For central hospitals to undertake effective performance management, they need accurate, accessible and processed information that is a true reflection of their operational activities. The development of an integrated performance management system (IPMS) is a longer term intervention due to the fact that it is dependent on outputs from various other interventions including strengthening of the HMIS. So far data verification and integration formats were analysed and possible gaps identified by the external consultants. Although discussions were held on the data integration, data sets and formats, integration of information was not finalised. It is anticipated that in the next quarter work will commence on reporting outputs and reaching agreement on an appropriate programming medium.

3.2 Documentation of hospital management systems

In order to improve day-to-day hospital management the programme embarked on the development of policy and procedure manuals for all management systems. Initially most of the documentation work has been done at Queen Elizabeth Central Hospital (QECH) with a role out to LCH planned in the next quarter. Areas covered include financial management (revenue collection) and procurement, non-clinical support systems (domestic and administration systems), clinical systems and clinical support systems (radiography, laboratory, pharmacy).

Relevant legislative documents were purchased from the Government Printing Press in Zomba and policy documents were collected from the Ministry of Health. Task teams were established for each area. All systems/processes/procedures that need to be documented were identified. Task team members then selected areas they would focus on and then went ahead with documentation. Where no procedures are in place a prototype was developed by an external or local consultant. Currently, initial drafts are being circulated to task team members at QECH for their input. In the next quarter, the

Hospital Management Strengthening Team will run a second round of task team workshops where comments made to the documents will be discussed and changes made. Thereafter, within the same next quarter, the documents will be presented to management and once approved, they will be incorporated into the Administration Procedure Manual. It is also anticipated that towards the end of the next quarter the intervention will be rolled out to LCH.

Based on the Legislative documents, Transport Task Team drafted procedures at a workshop that was held on 22nd March, 2004. The draft procedures are currently being typed. Changes will be made later in the next quarter when the team will meet and thereafter the final document will be incorporated into the Administration Procedures Manual.

3.3 Documentation of personnel management

Several interventions were undertaken and these were also driven from QECH. They include the following:

- Development of Human Resources Policy and Procedure Manual
- Development of a framework for the Human Resources Plan
- Development of a Registry System
- Development of Leave Management System
- Development of a Management Toolkit for senior hospital managers

3.3.1 Human Resources Policy and Procedures Manual

Task Teams were established and a workshop was organized where draft documents were developed using legislative documents that were obtained from Zomba and policy documents obtained from the MOH. The draft documents have been circulated to all task team members. In the next quarter a second round of task team workshops will be arranged where comments will be discussed and incorporated into the final document to be presented to management.

3.3.2 Framework for Human Resources Plan

A draft framework for a Human Resources Plan was produced by the external consultant and handed over to the Hospital Directors and Hospital Administrators at both QECH and LCH for their comments. QECH management made changes and recommendations to the document. The document now awaits finalisation of the strategic plan and hospital establishment list. It is envisaged that a revised integrated Human Resources Plan will be presented at the end of the next quarter in June 2004.

3.3.3 Registry System

The framework for Registry system was developed with consultation of the Hospital Administrator and Registry staff at QECH and was handed over to management team for

their comments and recommendations. The system includes procedures for mail handling and Human Resources Registry. It is expected that the pilot run of the new system will be completed by May 2004. Thereafter, the system will be rolled out to LCH possibly by end of next quarter.

3.3.4 Leave Management System

The system was developed by Karen Campbell using Malawi Civil Service Leave Management Legislation obtained by the team from Zomba. Draft procedures developed were given to the QECH Human Resources Task members and the management team for their input. Plans are that the leave policy will be incorporated into the Human Resources Policy Manual in the next quarter.

3.3.5 Management Toolkit

Management Toolkit Framework was developed and the first version will be presented to management of the two central hospitals towards the end of the next quarter.

4. Improved hospital functioning

4.1 Establishing organisational structures based on cost centre management

The development of cost centres is seen as a significant step in transforming hospitals from passive recipients of donated goods, to active recruiters of resources that are channeled and managed in a coordinated and prioritized manner. The whole process of developing cost centres includes the creation of the current organisation structure, and staff establishment to enable useful analysis. This took slightly longer than anticipated but is still on target. The requirements were established and due to the HMIS, DHIS and current reporting unit arrangements, it was decided that the current service delivery framework be used as base for the cost centres. The first draft cost centre organisation structures were developed and discussed with management of both LCH and QECH. The sub programme budgeting process is a main constraint to allocating budgets to cost centres due to mixed cost centres in one sub programme. The cost centres will be linked with the appropriate sub programme to enable effective reporting and with consideration of the requirements of the Ministry of Health (MOH) and Treasury.

The intervention focusing on financial reviews joined in with budgeting for cost centres and the reviews are also following the draft cost centre structure. It is anticipated that the final draft cost centre structure will be finalized with receipt of final adjustments and comments from hospital managers during the first week of April 2004. Staffing norms and theoretical resource allocation to cost centres will be done thereafter. Individual hospital reports propose milestones for cost centre development and resource allocation in the next quarter.

4.2 Accounting and revenue management

Strengthening of Revenue Management is being done through the development and implementation of a revenue management model. At both LCH and QECH various meetings and discussion groups were conducted addressing the revenue processes and patient fee structures, and registers. Gaps were identified the existing system handling transfer of cash from patients to cashiers and then to accounts and these were addressed in the revised processes which are being developed.

The patient fee structure received from the MOH was incorporated successfully into the revenue management tool, but required further revision due to the fact that the hospitals were not using the same fee structure. Meetings were held with key role players in paying units at both hospitals to establish the variance. It emerged that several fee structures were in use.

The Hospital Autonomy programme has supported a task team on hospital fees commissioned by the JIP Subcommittee on Hospital Autonomy to revise the fees. This task team has embarked on a process of costing actual services and simplifying the fee structure based on costing bands. The revised fee structure will be incorporated into the revenue model once finalised.

The revenue model as such was adjusted to reflect the patient classification system currently utilised by the central hospitals. Piloting of this intervention was due to be undertaken in March 2004, but could not be done due to the confusion surrounding the fee structure.

4.3 Development of clinical guidelines

Clinical and clinical support task teams have been initiated at QECH and have prioritized processes and procedures that need to be documented. Clinical guidelines are available in most clinical departments. The primary concerns of the clinicians at this stage are focused on the resource, organisational and management constraints to implementing guidelines. Two good examples are the constraints to implementation of the following guidelines:

4.3.1 Infection prevention

A comprehensive set of guidelines (the document is over 200 pages long) has been developed with support from JHPIEGO that addresses eight different practice settings and five support services. Both LCH and QECH have been identified as pilot sites for their implementation. The project has supported training activities related to the implementation of the infection control program at LCH and QECH. However, massive cuts in funding for recurrent expenditures have place considerable constraints on the availability of essential equipment and supplies required to implement this program effectively. Furthermore, critical shortages of nurses to the extent that 70 bed departments may not even have a registered nurse on duty at certain times has meant that only the most crucial lifesaving interventions are undertaken. Under these circumstances it is virtually impossible to get staff to focus on implementing these new guidelines.

4.3.2 Clinical referral guidelines

The comprehensive set of clinical referral guidelines (the document is 186 pages long) has been developed by clinicians in Lilongwe. These guidelines have been developed for over 150 clinical conditions within the various specialties. These guidelines address the main clinical features of each condition, key investigations that should be undertaken to confirm the diagnosis, treatment guidelines and criteria for urgent and non-urgent referral. These guidelines have been developed to promote a functional referral system with continuity of care between the various referral levels. However, most of these guidelines remain largely theoretical because the referral system is dysfunctional and the hospitals remain overloaded with patients that should be treated at the district level. It is recognized that the main reason patients bypass the lower levels is the lack of skilled staff, medical supplies, suitable facilities and other resources. It is also difficult and unpopular for hospitals to turn away patients. Establishing an effective hospital service that provides quality of care will therefore require substantial restructuring and reorganisation of PHC and hospital services rather than the development of more clinical guidelines. Through a variety of other interventions the hospital autonomy programme is attempting to address these serious problems.

4.4 Key performance indicators used by hospital management teams and strengthening of the Health Management Information System

Subsequent to the baseline survey conducted in December during which problems in the basic data collection process were identified, an external consultant from HISP has focused on data collection tools being used in Lilongwe Central Hospital. The following has been accomplished in this regard:

- Linkages were made with various clinical departments in order to assess their information needs (in particular paediatrics, medicine, obstetrics and gynaecology, anaesthetics, and briefly with surgery);
- An initial report based on the data in the Paediatric Management Information System was drawn up;
- Data collection tools were developed for various OPD units – this was an important step because recording on OPD attendances appeared to be undercounting the workload;
- Clarification obtained on the likely reporting units;
- Development of the clinic audit tool, and testing of this on two clinics, after which the tool has been able to be revised. It is now ready for use.

Currently the focus is on data that is coming in from the reporting units and preparation of the HMIS for initial reports to management and clinical heads. An exciting development has been the request from the HMIS officials from the MOH to be involved in the assessment undertaken by the external consultant on his next quarter's visits to the central hospitals. This is seen as a positive development in that if there are adjustments

that need to be made to the HMIS in hospitals, it is important that this carries the approval of the MOH.

The current scenario in the hospitals is that up to now units report on their activities every three months. From a management point of view, this is too long an interval to enable management to be responsive to changing trends, and as result from the next quarter onwards units will report on a monthly basis. This will enable management to receive monthly reports on activities which will improve their awareness of trends in the wards.

The program is cognizant of the constraints under which hospital staff have to work due mainly to the shortage of personnel, and has to find ways of reducing the workload on various cadres of staff (or at least not increasing their workload), while at the same time improving data collection systems. While it will take some time before significant improvement in the quality of the data coming from the reporting units is seen, some basic interventions have been introduced related to the collection of data, and it is hoped that this will contribute to improved reporting on information. As managers view their data and indicators, this will provide further impetus to improve data quality.

During the same quarter, simple database were developed for Radiography and Anesthetic departments at LCH. These are helping the departments to collect accurate and high quality data.

5. Improved health systems functioning

5.1 Strategic assessment of service delivery

In Malawi central hospitals were set up to provide specialist health services (level II and level III services). In practice however they predominately provide level I hospital care and PHC, both of which should be the responsibility of district health facilities (district hospitals, health centres and below). The Hospital Autonomy Programme aims to improve the efficiency of health services delivery by supporting moves towards devolving level I hospital care to lower levels of the health system. This will require:

- Strengthening of primary level health facilities;
- Establishing “gateway” health centres within close proximity to central hospitals to deal with PHC problems;
- Re-structuring hospital services in the main urban centres;
- Strengthening referral practices and procedures.

Decentralisation workgroups have been meeting in Blantyre and Lilongwe on a regular basis for several months to develop a work plan for devolution of services from central hospitals to local district health services. These work plans take into account the type of services, the roles of various role-players and stakeholders and the availability of resources (funds, people, supplies, buildings and equipment). Finalisation of work plans has been delayed and the JIP Subcommittee on Hospital Autonomy recommended that

progress would be facilitated if the work groups used a standard template or framework for planning the decentralisation of services. The framework for decentralisation addresses the following:

- Documentation of all services at central hospitals by entry point which includes identification of all entry points, volume and type of services provided, hospital admissions, primary and secondary providers of care;
- Analysis of services to determine appropriate service delivery point and includes identification of services that could be provided by district institutions as well as services that should not be devolved to districts;
- Implications of shifting services to the district health system in terms of funds, human resources, buildings, equipment, supplies and the referral system;
- Development of alternative approaches to devolution of services
- Formulation of an action plan
- Monitor implementation

It became apparent to the decentralisation team that strategies could not be developed for devolution of services without a comprehensive analysis of the volume and type of services currently provided by district facilities, an understanding of the resources available at district institutions and their capacity to accommodate additional workload that may be devolved from central hospitals. The facility survey will provide most of this information. A national survey of health facilities undertaken by JICA in 2001 provides some of this information. The balance of the information required will be collected by this district health facility survey.

High priority will also be given to ensuring that decentralisation planning processes are informed by an understanding of client and community health needs and perspectives of the quality, accessibility and affordability of services. Common issues that have emerged from studies that have investigated community perceptions of public and other health services in Malawi are concerns about drug availability, poor client-provider interaction, low confidence in the quality of diagnosis and treatment, long waiting times, long pathways to care, and lack of confidentiality. Nevertheless, despite these studies there is limited detailed information on clients' health care seeking behaviour and perceptions of public and other health services that may lead planners to appropriately shape decentralisation plans in particular districts. Of particular interest to planners in Blantyre and Lilongwe is to find out more about which health facilities in the district are by-passed in favour of others, by whom and for what reasons, and to what extent the referral system is working. The District Health Offices in Blantyre and Lilongwe have therefore identified the need to undertake a client survey in order to inform their plans for decentralisation.

All three surveys envisaged (i.e. the central hospital survey, the district facility survey and the client survey) provide unique information and different perspectives of health

service delivery and utilisation patterns in Lilongwe and Blantyre health districts that will inform the development of alternative scenarios for decentralisation of services.

The planning of these surveys was completed this quarter and implementation will be undertaken in the next quarter.

6. Other key activities

6.1 Appointment of long term technical assistants

Both positions of Hospital Management Technical Assistant (HMTA) for LCH and QECH are now filled. The Hospital Systems Development Specialist (HSDS) post was advertised in South Africa at the request of the MOH but no suitable candidates were short-listed. The post will be advertised again in April 2004.

6.2 Support to JIP subcommittees

The programme facilitated the meetings and drafted the minutes of the JIP finance subcommittee on the 5 February and 5 March 2004 and the JIP subcommittee on hospital autonomy on the 6 February and 5 March 2004.

6.3 Introduction of the mentorship program

Two senior hospital managers from South Africa have agreed to participate in a mentorship program to support the hospital directors at LCH and QECH. The program was initiated by an informal weekend retreat followed by visits to the central hospitals. The program will provide personal support to the hospital directors as they embark on difficult change management exercise. The mentors by virtue of their knowledge and senior management positions in the public service in South Africa, are proving to be extremely useful resources for a wide range of interventions.

6.4 Project planning and administration

The following project planning activities were undertaken:

- Review of baseline survey reports and plan interventions with hospitals for the next year
- Monthly updates of activity plans
- Establishment of HA offices at LCH and QECH
- Review of draft national strategic framework for hospital autonomy and submit to JIP.
- Initiated mentorship program for LCH and QECH hospital directors (see report attached)
- The Scopes of Work for several external consultancies that are part of the Work plan for 2003/04 were prepared.

7. Important next steps

- Submission of Draft Policy on Hospital Autonomy to the Main JIP Meeting for approval (May 2004).
- Review of draft bill of hospital autonomy in light of Policy on Hospital Autonomy.
- Continue with documentation of management systems at LCH and QECH.
- Visits by the Hospital Directors to their mentors in SA to “shadow” them for a week and explore options for institutional linkages.
- Sensitize LCH staff to hospital autonomy through production of a regular bulletin.
- Continue with interventions on decentralisation of management, strategic and operational planning and financial management.
- Continue interventions on strengthening HMIS system.
- Initiate investigation into appropriate accounting system for hospitals (May/June 04).
- Assist LCH with the development of a transport management database.
- Undertake client surveys and health facility surveys to establish a database of information that will inform the development of strategies to facilitate decentralisation of services from central hospitals to district health facilities.

Annex VI

Operations / Administration Activities

1. Vehicles

The balance of three (3) Toyota Landcruisers was received from Toyota Malawi in late February 2004 for a total of 12 project vehicles purchased to date (11 Landcruisers and one Toyota pick-up double-cab). MSH continued to retain the four (4) ex-CHAPS vehicles to be handed back to USAID in April 2004. Plans are underway to procure a sedan vehicle specifically for use by the Hospital Autonomy team to meet the transportation needs of the frequent external consultants coming to Malawi, in the meantime, USAID granted approval for retention of the ex-PHR+ Pajero for this purpose.

2. Computers

With the erratic power supply by ESCOM, we continued to experience problems with the flat screens purchased for desktop computers both at the central office and in the districts. Of the 38 desktop computers purchased with the original consignment, 21 screens have been lost to the power problems, of which 9 have been replaced by the supplier in South Africa. Presently, we await replacement of 14 screens. We have also been experiencing problems with inadequate supply of 3-phase power to the building which necessitated our running on the back-up generator for extended periods of time. We managed to resolve this problem by insisting on a meeting with ESCOM's regional manager for Central Region who detailed a team of technicians to work diligently on the problem. The need was identified for laptops for the district offices which will be added to the procurement plan for the next quarter. The district offices frequently need to carry computer equipment to trainings sessions and workshops and laptops are ideal for this. The district offices also have no backup power which renders all their computers unusable during power outages. Having laptops provides greater capacity to cope with these interruptions. Plans were made to provide eight (8) desktop computers for the pharmacies at the district hospitals. Plans were also made to have external consultancies to resolve outstanding remote email access issues, as well as the management of the IT function for the Malawi office.

3. Radios and Refrigerators

The baseline survey established a total of 48 health facilities in the eight project districts without working radio communication. An exercise was initiated to separate from among these those facilities with faulty radio equipment and those that had no equipment at all, and to provide repair or procurement solutions. Discussions were initiated with Brian Poole, communications consultant for UNICEF in Malawi, who

is undertaking a similar exercise for 10 UNICEF impact districts, four of which happen to be MSH districts.

The survey also identified the need for 13 refrigerators in the districts but upon consultations with the National EPI Program, strong assurances were given that adequate refrigerators had been procured for all health facilities. MSH will seek to link these 13 facilities with the EPI program to ensure the fridges are provided.

4. Construction

Invitations were sent out to four architects firms based in Lilongwe to bid on provision of architectural consultancy and project management for construction projects in Balaka (MSH office), Lilongwe Central Hospital (hospital autonomy office and computer lab), Ntcheu (VCT center), Balaka (MSH office), Chikwawa (MSH office) and Mulanje (secure car port). The firm of Norman & Dawbarn was selected based on price proposal and past performance references. Detailed architectural drawings and cost estimates were prepared and construction firms invited to bid for the work. The construction schedule calls for award of contracts on/around May 18, 2004, completion of the works in Chikwawa and Mulanje in 6 weeks, and 16 weeks in the other locations.

5. Activity Management Process

With increased activities in the districts and the central office, it has become necessary to hire an Activities Coordinator to provide liaison between the districts and the technical and operational functions of the central office. It is anticipated that a suitable candidate will be identified internally. Plans were made to bring in all the technical staff from the districts for a 2-day intensive session at the central office at the end of March to consolidate workplans for the coming quarter (April-June 2004). The operations team will continue in its efforts at further refinements to the activity management process.

Annex VII

Activities of the Previous Quarter

Activity description

Centrally Defined Activities

Development of District Proposals for Global Fund
National Annual Review for malaria
Support to the PHC Module Training for MSH district and DHMT staff at College of Medicine
Participation and support in DIP Software Training
Initiation of Supervision Discussions with DHMTs Programme Managers

Balaka District

Training of Health Workers in ITN management
Support to DIP review and monitoring exercise
Support to C-IMCI Task Force meetings in Balaka
Support to C-IMCI Exchange visits
Support to DIP development and review
Printing of district referral forms
C-IMCI training for 20 district working members
Support to C-IMCI Technical working group
Exchange visit C-IMCI technical working group
Support to DIP Software Training
Support to Participatory Rural Appraisal
Sub Analysis of Baseline Data

Chikwawa District

DHMT needs assessment
Support to Participatory Rural Appraisal
Support to DIP review and monitoring exercise
DRF: ITN Community mobilization
Support to DIP Software Training
Review of job description and updating DHMT roles and responsibilities
HMIS Health facility supervision
Support to VCT Out reach Clinics
Training of VCT VCT Counsellors

Kasungu District

Identification of impact areas for the C-IMCI activities
Sensitization of Chiefs in the impact areas for C-IMCI activities
DIP Development
DIP Monitoring
DHMT needs assessment
Reactivation/ Formulation of ITN Committees
C-IMCI workshop
Support to Formative Research for the BCI component

Mangochi District

DIP monitoring and review
Support to DIP budget session
Dissemination of Baseline Survey findings at DIP preparatory meeting
DIP Software training
Sensitization of area development committee on C-IMCI activities
DIP Budget session

Mulanje District

Support to IMCI District Planning workshop
DHMT needs assessment
Infection Prevention Baseline assessment
Support to Extended DHMT meeting
DIP cluster meeting
Support to DIP development, finalization, costing, priority setting and report writing
Baseline Data sub-analysis and report writing
Support to Participatory Rural Appraisal

Mzimba District

Support to DIP development, review and monitoring
DIP Software Training
DHMT needs assessment
Clinic visits to orient John Rhode
Identification of impact areas for the C-IMCI activities
Sensitization of Chiefs in the impact areas for C-IMCI activities
Refresher training course for HSAs
Orientation of hospital attendants on OR and DOT mgt

Ntcheu District

Conduct assessment of impact areas for C-IMCI activities
Support to DIP development, review and monitoring

Salima District

DHMT needs assessment
Support to a Training needs workshop on HIV/AIDS
Infection Prevention Baseline assessment
Supporting Pharmacy Assistants to organize drug stores
Support to DIP development, review and monitoring
DIP Software training
Baseline Data sub analysis
Support to Participatory Rural Appraisal

Central hospital

Support to Hospital mentorship program
Support to JIP meetings
Support to the Strategic framework documentation with MOHP officials and hospital directors
Support to Task Force meeting to finalise patient tariff
Departmental Planning meeting on user fees and strengthening Management Systems